Patient Payment Form

Please indicate, by signing and dating this form, whether you want to have the PapSure® exam.

☐ **Yes. I authorize my physician to do the PapSure exam together with my normal Pap smear, and I accept the financial responsibility for the Speculite® and the PapSure visualization exam.**

☐ **No. I choose not to have the PapSure exam.**

Name (Please Print) ______________________________

Signature ______________________________ Date ______________

Be PapSure™

WATSON Diagnostics, Inc.

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